



EDITORIAL

Public Health Priorities at Subnational Levels

David Sharp

A museum dedicated to the rise and fall of the British commercial waterways system was not expected to provide thought for an editorial on what priorities public health agencies should be giving to noncommunicable diseases. But there it was—a certificate declaring a named canal boat as fit, under 1936 public health legislation, to be a home. Housing came under the postwar Ministry of Health in the United Kingdom in part because of the link with the prevention of communicable diseases, a concern most associated with public health historically, and not all that long ago. In 1866, the east end of London, yet to benefit from the capital's new sewer system, experienced a severe cholera outbreak in which more than 5,500 people died.¹ There are no grounds for complacency (reemerging diseases such as tuberculosis have seen to that), but drinking water and sewage disposal and immunization programs have eliminated much of the infectious-disease risk to people living in cities in the industrialized world. Today, three-quarters of US health care costs can be attributed either to chronic and noncommunicable diseases or to chronic, noncommunicable causes of disease.² So, do city health departments' programs and budgets reflect that shift in emphasis? No, say Mari Georgeson and colleagues³ in their report in this issue of a survey of metropolitan health departments, members of the Big Cities Health Coalition.

Among other questions, Georgeson et al.³ asked what proportion of the departmental budget had been allocated to chronic diseases in 2003. That varied hugely from 0.1% to 10%. So did chronic disease expenditure per head of population, from less than \$1 to over \$7. Because the top and bottom cities in these two rankings were not the same, it does not take much to calculate that also highly variable is the total spend on all matters coming under the departments' responsibilities—for instance, \$607 per head of population in Philadelphia compared with \$50 in Houston. The outside observer is likely to be even more confused by the sources of funds. How is it that some cities (e.g., Boston) get a lot of Federal support for chronic disease programs, whereas others get nothing? Not asked, though politicians are bound to pose the question, is whether cities in which more is spent have, or will have, better mortality and morbidity figures for the very diseases that the programs are tackling.

To make comparison with the United Kingdom would be very difficult, largely because of the different way that medical and public health services are delivered. Here, local government has responsibility for environmental health, which includes food hygiene but also air pollution, a factor in asthma, which is one of the US coalition's spend areas. The central Department of Health and regional public health directors look at the broader picture, and the 2004 policy white paper⁴ had a strong focus on noncommunicable disease, including tobacco-related illness which

accounts for almost half the expenditure revealed by the US survey. National Health Service allocations generally do try to address the imbalance expressed in the “inverse care law,” which states that medical care funding does not reflect local disease burden,⁵ and there are signs of similar thinking in the United States too.

Georgeson et al.³ ask whether US big cities are “shortchanged.” That some are seems indisputable but shortchanged “compared with what?”—with rural areas, with not so big cities? The title of a 2005 report from Trust for America’s Health (funded by the Robert Wood Johnson Foundation) includes the word *shortchanging* too.⁶ State-by-state statistics for federal funding show huge variations, just as the Big Cities Health Coalition found. To take an example from a mass of detailed state figures, the average allocation of Centers for Disease Control and Prevention dollars last year was \$14.88 per head of population, but in Louisiana it was \$142.75, whereas North Dakota picked up just \$1.50. The latter state is healthier than the former, says the report, but one doubts whether the morbidity burden of the two differs by a factor as large as 100.

However health services are managed and funded, programs directed at the prevention of chronic illness must have a strong local element and the flexibility to reflect local demographics and specific problems. UK public health strategy recognizes that.⁴ As Georgeson et al.³ note, the low level of direct Federal funding for chronic disease prevention is a missed opportunity because prevention has to take advantage of the links that local health departments have access to. In any country, there will be debate about the balance to be struck between health funding from central sources compared with locally raised taxation, and the existence of a National Health Service does not make the United Kingdom immune from that debate in respect of disease prevention activities. But with variations as huge as those revealed in recent US surveys of big cities and states,^{3,6} the rationale behind some budgets, and locally channeled Federal allocations especially, is most perplexing.

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